Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Department of Health
HIV Client Services
and
Department of Social and Health Services
Medical Assistance Administration

Title XIX(Medicaid) HIV/AIDS Case Management

WAC 388-539-0300 and 0350
Billing Instructions

October 2003

About this publication

This publication supersedes all previous HIV/AIDS Case Management Billing Instructions and Numbered Memorandum 03-35 MAA.

This document is to be used for billing purposes only. Please refer to the Department of Health's Case Management: A Guide for Assisting Person's Living with HIV/AIDS (DOH publication #410-014) for a complete guide to the HIV/AIDS Case Management Program. Refer to the **Important Contacts** section of this document to find out how to order this DOH publication.

Published by the Medical Assistance Administration (MAA)
Washington State Department of Social and Health Services (DSHS) in collaboration with
Washington State Department of Health, HIV Client Services.
October 2003

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)].

How do I become a DSHS provider?

Call the Department of Health to request a provider application be sent to you:

HIV Client Services
(360) 236-3453

Where do I send my claims?

Division of Program Support
PO Box 9253
Olympia WA 98507-9253

Electronic Billing?

Go to:
http://maa.dshs.wa.gov/ecs

Where can I view and download MAA's Billing Instructions or Numbered Memorandum?

Go to MAA's website at:
http://maa.dshs.wa.gov
Click on "Provider Publications/Fee Schedules".

Where do I write/call if I have questions on…?

Provider participation, case management standards and reporting requirements?

Department of Health
HIV Client Services
PO Box 47841
Olympia, WA 98504-7841
(360) 236-3453

Payments, denials, general questions regarding claims processing, Healthy Options?

Medical Assistance Customer Service Center 1-800-562-6188

Private insurance or third party liability, other than Healthy Options?

Division of Customer Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136

Where can I obtain a copy of the DOH's Case Management: A Guide for Assisting Persons Living with HIV/AIDS?

Write/call:
HIV Client Services
PO Box 47841
Olympia, WA 98504-7841
(360) 236-3453

Definitions

The section defines terms and acronyms used in this booklet.

AIDS - Acquired Immunodeficiency Syndrome. A disease caused by the Human Immunodeficiency Virus (HIV).

Client - An applicant for, or recipient of, DSHS medical care programs.

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Department of Health (DOH) - The state Department of Health which, in accordance with an interagency agreement, administers the daily operations of Title XIX targeted HIV/AIDS case management.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

HIV - Human Immunodeficiency Virus.

HIV/AIDS Case Management - Services which assist persons infected with HIV to: live as independently as possible; maintain and improve health; reduce behaviors that put the client and others at risk; and gain access to needed medical, social, and educational services.

HIV Client Services - The office of the Division of Community & Family Health, Department of Health, which oversees the daily operation of the Title XIX HIV/AIDS Case Management Program.

ISP – Individual Service Plan – Identifies and documents the client's unmet needs and the resources needed to assist in meeting the client's needs.

Maximum Allowable - The maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs. (Medicaid is also called Title XIX)

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification Card – The forms DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

Medically Necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Remittance And Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the purpose of the Title XIX (Medicaid) HIV/AIDS Case Management Program?

The purpose of theTitle XIX HIV/AIDS case management program is to assist persons infected with HIV to:

- Live as independently as possible;
- Maintain and improve health;
- Reduce behaviors that put the client and others at risk; and
- Gain access to needed medical, social, and educational services.

[Refer to WAC 388-539-0300]

MAA (the administration within DSHS that administers the acute care portion of the Title XIX Medicaid program) has an interagency agreement with the Department of Health (DOH) to administer the HIV/AIDS case management program for eligible Medicaid clients.

[Refer to WAC 388-539-0300(2)]

Who provides Title XIX HIV/AIDS Case Management Services? [Refer to WAC 388-539-0300(3)]

Agencies approved by the Department of Health's HIV Client Services.

How does an agency request approval from DOH to provide these services?

An agency requests approval from DOH by completing all of the steps in the Title XIX Provider Application Process and submitting all required documents to DOH.

Where can an agency get the information needed to complete the provider application process?

Refer to the Department of Health's Case Management: A Guide for Assisting Persons Living with HIV/AIDS for specifics on provider requirements, or call HIV Client Services at (360) 236-3453. Refer to the **Important Contacts** section of this billing instruction for information on ordering a copy of this DOH publication.

Client Eligibility

Who is eligible to receive Title XIX HIV/AIDS Case Management? [Refer to WAC 388-539-0300(1)]

To be eligible for Title XIX-reimbursed HIV/AIDS case management services, an individual must:

- Have a current medical diagnosis of HIV or AIDS;
- **Not be receiving** concurrent Title XIX HIV/AIDS case management services through another program;
- Require:

  - ✓ Assistance to obtain and effectively use necessary medical, social, and educational services; or
  - ✓ 90 days of continued monitoring (see page C.2 for more information).

-AND-

- Present a DSHS Medical Identification card with one the following medical program identifiers:

Medical Program Identifier	**Medical Program Name**
CNP	Categorically Needy Program
CNP – CHIP	Children's Health Insurance Program
LCP-MNP	Limited Casualty Program - Medically Needy Program
LCP-MNP	Limited Casualty Program/MNP
LCP-MNP Emergency Medical Only	Limited Casualty Program/MNP Emergency Medical Only
Title XIX HIV/AIDS Case Management services are not covered if the medical program identifier on the client's DSHS Medical ID card is not listed in this table.	

The client's DSHS Medical ID card must show eligibility for the date(s) services are rendered.

Are clients who are enrolled in an MAA managed care plan eligible for Title XIX HIV/AIDS Case Management?

Yes! A client enrolled in an MAA managed care plan is eligible for Title XIX HIV/AIDS Case Management **provided the client meets the criteria listed on the previous page**. These services do not require a referral from the client's managed care plan. Use these billing instructions and bill MAA directly. **Be sure to use the appropriate billing form and mailing address as specified in this billing instruction.**

Billable Services

What services are billable?

MAA reimburses Title XIX HIV/AIDS case management providers for the following three services:

1. Comprehensive Assessment

MAA reimburses for only one comprehensive assessment per client unless the client's situation changes as follows:

- ✓ There is a 50% change in need from the initial assessment; or
- ✓ The client transfers to a new case management provider.

The assessment must cover the areas outlined in DOH's Case Management: A Guide for Assisting Persons Living with HIV/AIDS. [Also listed in WAC 388-539-0300(1) and (5)]

MAA reimburses for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the assessment is completed during a month the client is eligible for Medical Assistance and the ongoing case management has been provided.

2. HIV/AIDS Case Management – Full Month

MAA reimburses for one full-month case management fee per client, per month.

Providers may request the full-month reimbursement for any month in which the criteria listed in DOH's Case Management: A Guide for Assisting Persons Living with HIV/AIDS have been met and the case manager has an individual service plan (ISP) in place for 20 or more days in that month. [The criteria are also listed in WAC 388-539-0300.] Monitoring can be billed under this service (see page C2).

3. HIV/AIDS Case Management – Partial Month

Providers may request the partial-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and an ISP has been in place for fewer than 20 days in that month. Monitoring can be billed under this service (see page C2).

Partial month reimbursement allows for payment of two case management providers when a client changes from one provider to another during the month.

When is monitoring a billable service?

Monitoring is a term used when a client becomes stabilized and no longer needs an Individual Service Plan (ISP) with active elements. This applies to clients who have a history of recurring need and instability and will likely require further assistance at a later date.

Case management providers may bill MAA for up to 90 days of monitoring past the time the last active service element of the ISP has been completed and the following criteria have been met:

- Document the client's history of recurring need;
- Assess the client for possible future instability; and
- Provide monthly monitoring contacts.

What procedure codes must be used to bill MAA for monitoring?

Use the following procedure codes and modifiers to bill MAA for monitoring:

HCPCS Code	Modifier	Description
T2022 Limited to dx 042 or V08	U8*	**Case management, per month.** Full month case management services
T2022 Limited to dx 042 or V08	U9*	**Case management, per month.** Partial month case management services

*Modifiers U8 and U9 are payer-defined modifiers. MAA defines modifier U8 as "full month" and U9 as "partial month."

When can a client be reinstated from a monitoring status to active case management?

A client can shift from monitoring status (ISP without active elements) to active case management status upon documentation of need(s). Providers must meet the requirements in WAC 388-539-0300 when a client is reinstated to active case management.

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: (1) for initial claims; and (2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the timeperiod listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee must I bill MAA?

Bill MAA your usual and customary fee.

What records must be kept?

Specific to the Title XIX HIV/AIDS Case Management program

Please refer to the Department of Health's Case Management: A Guide for Assisting Persons Living with HIV/AIDS for required documentation specific to the Title XIX HIV/AIDS Case Management Program.

General to all providers [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

Fee Schedule

Use the following procedure codes with the appropriate modifiers when billing for Title XIX HIV/AIDS case management services:

Procedure Code/ Modifier	HCPCS Description	Maximum Allowable Effective 7/1/03
T2022-U8 **Limited to diagnoses** **042 or V08**	**Case management, per month.** **[Full Month]** A full month rate applies when: A. The criteria in WAC 388-539-0300 have been met; and B. An individual service plan (ISP) has been in place 20 days or more in that month.	**$172.00**
T2022-U9 **Limited to diagnoses** **042 or V08**	**Case management, per month.** **[Partial Month]** A partial month rate applies when: A. The criteria is WAC 388-539-0300 have been met: and B. An ISP has been in place fewer than 20 days in that month.	**$86.00**

NOTE: MAA reimburses full or partial month fees during monitoring per WAC 388-539-0350. See page C2 for a complete description of these services.

Procedure Code	HCPCS Description	Maximum Allowable Effective 7/1/03
T1023 **Limited to diagnoses** **042 or V08**	**Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter** **(Use this code for the comprehensive assessment)** This service must meet the requirements of WAC-539-0300 (1) and (5), and is reimbursed only **once** unless the client's condition changes as follows: A. There is a 50% change in need from the initial assessment; or B. The client transfers to a new case management provider. A comprehensive assessment is reimbursed in addition to a monthly charge (either full or partial) if the assessment is completed during the month a client is Medicaid eligible and ongoing case management has been provided.	**$137.75**

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Use blue or black ink only! Do not use any other colored ink when making notations on claims. Also, do not use highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. Colored ink and/or highlighters will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions

1a. **Insured's I.D. NO.**: **Required**. Enter the MAA Patient (client) Identification Code (PIC) alphanumeric code exactly as shown on the client' DSHS Medical Assistance ID card. The PIC usually consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: **Required**. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: **Required**. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, federal health insurance benefits, military and veteran's benefits) list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: **Required**. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. If the client has insurance secondary to the insurance listed in *field 11*, enter it here. When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9A. Enter the other insured's policy or group number *and* his/her Social Security Number.
9B. Enter the other insured's date of birth.
9C. Enter the other insured's employer's name or school name.

9D. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc. are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: **Required**. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11A. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

11B. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11C. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11D. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes.* If **11d** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17A. **I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PCCM referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

19. **Reserved for Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*.

21. **Enter Diagnosis 042 or V08, whichever is appropriate**) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only ONE (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 form. Total each claim separately.**

24A. **Date(s) of Service**: **Required**. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 04, 2003 = 100403).

Do not use slashes, dashes, or hyphens to separate month, day, year (MMDDYY).

24B. **Place of Service**: **Required**. The following is the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
11	Office
12	Client's residence.

24D. **Procedures, Services or Supplies CPT/HCPCS**: **Required**. Enter the appropriate procedure code for the services being billed.

24E. **Diagnosis Code**: **Required**. Enter the ICD-9-CM diagnosis code **042 or V08, whichever is appropriate**.

24F. **$ Charges**: **Required**. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: **Required**. Enter the number one.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Control Number*.

28. **Total Charge**: **Required**. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or patient paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: **Required**. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: **Required**. Put the name, address, and telephone # on all claim forms.

GRP#: Required. Enter the seven-digit number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

HIV/AIDS Case Management

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): EF010150FREESA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FREES ELSA F

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 50 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): (360) 111-2222

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 042 . 3. . 2. . 4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11	01	03	11	30	03	11		T2022	U8	042	17200	1				
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 17200

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 17200

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

A-Z ASSOCIATES 1234 MAIN STREET
ANYTOWN WA 98000

PIN# GRP# 7412345

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

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